New Hampshire

Oral Isotretinoin Medications

NH Medicaid Prior Authorization

Request Form

First Health Services Corporation
A Coventry Health Care Company

Fax: 1-888-603-7696 Phone: 1-866-675-7755

Date of Medication Request: ___ ___ /___ ___ /___ ___ _

Section I: Patient Information and Medication Requested:

Name: (Last, First) _____ NH Medicaid Number:___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Date of Birth: ___ ___ /___ ___ /___ ___ ___ ___ Gender: ☐ Male ☐ Female

Drug Name:_____ Strength:_____

Dosing Directions:_____ Length of Therapy:_____

Section II: Clinical History:

1. Please provide the diagnosis/condition this medication is being prescribed to treat:

_____
_____
_____

2. Has the patient failed at least two conventional acne treatments? ☐ Yes ☐ No
   Please list treatment failures and dates:

_____
_____
_____
_____

3 Are patient and provider registered, and meet all the requirements of the iPLEDGE® risk management program; INCLUDING if appropriate, a confirmed negative serum pregnancy test and a plan for contraception in place?
☐ Yes ☐ No

4. Has patient used oral isotretinoin therapy in the past? ☐ Yes ☐ No
   If yes, please provide medication names and dates:

_____
_____

Please provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet

_____
_____
_____

Section III: Prescriber Information:

Print Name:_____ DEA Number: ___ ___ ___ ___ ___ ___ ___ ___ ___

Phone Number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Fax Number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

_____
Signature of Prescribing Provider

Revised 11/28/06